ACCESS

Newsletter of the Nebraska Office of Rural Health, Nebraska Health and Human Services System and the Nebraska Rural Health Association for all rural health stakeholders

Issue 45, July 2006

Next step in shared patient records

By Dave Howe

A big piece of groundwork has already been laid for delivering healthcare with greater efficiency and accuracy to behavioral healthcare patients at southeastern Nebraska hospitals. The focus is on a system for sharing electronic patient records between behavioral healthcare providers and hospitals.

Project director Wende Baker, executive director of Lincoln-based Health Partners Initiative, talks about how the system is expected to work.

When a behavioral health patient enters a southeastern Nebraska hospital emergency room, the hospital and primary care providers there will have immediate electronic access to that patient's records, which are maintained by his or her behavioral healthcare provider. The record includes patient identification by Social Security number, birth date and address as well as the patient's medical history, a list of the medications the patient is taking and a list of the patient's healthcare providers.

The shared records minimize the chance of conflicting or redundant treatment or medications.

Work began more than a year ago to create a system that can accomplish that goal while complying with information security and HIPAA privacy requirements. Funding for the effort comes from an AHRQ (Agency for Healthcare Research and Quality) planning grant, one of only 38 such grants awarded nationally.

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A Great Day for Dentistry

Festivals, celebrations, and town picnics are an annual rite of spring, especially in rural communities.

Among them is one Nebraska Panhandle event not surrounded by the hoopla of banners, bands, and beverages. But, it may be one of the area's most important spring happenings for under-served children who range in age from kindergarten to adolescence: Dental Day.

Through efforts by dozens of state and local healthcare organizations, individuals, and private donations (see boxed list of sponsors), about 190 under-served youths throughout the Panhandle received free dental care on the first Friday and Saturday of June this year. It's care they might not otherwise receive.

Many of these children are seeing a dentist for the first time in their lives. Some may need 12 or more fillings, said Dr. David Brown, Professor of Oral Biology and Executive Associate Dean of the University of Nebraska Medical Center College of Dentistry. He has been closely involved in Dental Days.

UNMC's Dental College has been conducting Dental Days twice a year in conjunction with a long list of cooperators and contributors for the past 5 years. All of those Dental Days were held in Lincoln until 3 years ago, when the dental college began holding one Dental Day in Lincoln and the other in the Panhandle each year.

An interesting aspect of Dental Day in the Panhandle is the real-time, interactive audio/video link between specialists at the Dental College in Lincoln and the dentists and children in dental chairs in the Panhandle. Telehealth is becoming an integral part of Dental Day, said Dr. Fouad S. Salama, Associate Professor and Director, Pediatric Dentistry Postgraduate Program in the UNMC College of Dentistry. If a dentist would like to consult with faculty at the Dental College on an unusual symptom or procedure—oral pathologists and periodontists, for example—an intra-oral

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Excellent line-up of topics and speakers at September Rural Health Conference

The upcoming Nebraska Rural Health Conference will showcase success stories and discuss emerging challenges and transformations in the rural health sector taking place right now. Each year, the conference serves as a meeting place for people concerned with the health of Nebraskans in rural areas, and looking for ideas and solutions for the complexities of frontier and rural health practice. Participants from all backgrounds are welcome, from a first-time consumer advocate to the experienced health professional.

The Nebraska Rural Health Association (NeRHA) Conference will be held September 7 and 8, 2006, at the Holiday Inn and Convention Center in Kearney, Nebraska. Participants will be challenged to envision a health care delivery transformation across the entire continuum focused on persons, not diseases or specific episodes of illness or trauma. Change will occur in how health services are paid for, how systems of care are organized, how professionals are trained, how patients interact with the system, and how providers are held accountable for patient outcomes. This conference will model new approaches in rural health care delivery related to finance, delivery, organization, and people.

Some of the sessions, centered on the theme, ***The Transformation in Rural Healthcare***, will be conducted by the following national speakers.

Transforming Rural Health Care: The Basic Ingredients

Presented by Mary Wakefield, Associate Dean, Center for Rural Health, University of North Dakota, Grand Forks, ND. This presentation will help attendees consider how recommendations from the IOM report, "Quality Through Collaboration" can be applied at the local, regional, and national levels. Specific attention will be given to transforming the workforce, health information technology, and community approaches to health and health care. Dr. Wakefield has expertise in rural health care, quality and patient safety, Medicare payment policy, workforce issues, and the public policy process. She has presented nationally and internationally on public policy and strategies to influence the policymaking and political process.

Health Information Technology: The Future Is Here.

As the nation's leading research agency on health care quality, safety, efficiency, and effectiveness, the Agency for Healthcare Research and Quality (AHRQ) of the U.S. Department of Health and Human Services, plays a critical role in the drive to adopt health information technology.

Jon White, MD, Health IT Portfolio Manager, of AHRQ will discuss the barriers that people in rural and small communities frequently face to getting good, appropriate care when needed. Recognizing the challenges of a short supply of physicians, hospitals, and other providers, not to mention the scarcity of public transportation, Jon will discuss how the AHRQ's health IT initiative, aimed at developing and implementing health IT in rural regions, will:

- Address unique barriers to IT implementation.
- Build and leverage telemedicine and telehealth networks.
- Integrate patient information with pharmacy, laboratory, scheduling, and health insurance information.
- Improve the safety, quality, and satisfaction of patients and providers.
- Foster community and regional partnerships and collaborations for health information exchange.

Rural Frontier EMS: New Agenda For The Future

Gary Wingrove is a manager for the Mayo Clinic's Gold Cross Ambulance Service in Minnesota and Wisconsin. He chairs the EMS Issue Group of the National Rural Health Association and participates on the EMS Task Force of the National Organization of State Offices of Rural Health. Gary notes that by focusing on restructuring, reimbursement, and recruitment, the National Rural Health Association hopes to improve and strengthen emergency services provided in rural and frontier communities. While new models are being considered, this session will focus on national EMS policy, pieces, procedures, and the practical side of what is going on—changes, privatization, trauma centers, telecommunications, and equipment availability.

Federal Rural Health Policy: A View from the Hill

Through the National Rural Health Association's (NRHA) government affairs office in Alexandria, VA, Alan Morgan advocates the NRHA's legislative and regulatory policies and positions before the Congress, federal agencies and the White House. The Association serves as one of the primary rural resources to elected officials, policy leaders, and other organizations on issues related to federally-sponsored rural health initiatives and programs. The successes of the past year have yielded policy changes, which will impact rural communities over the coming decade. This session is always enlightening, but because of the changing rural health landscape, there has never been a more important time for rural health advocates to make their voices heard.

Rural Health Policy and the 2006 Nebraska Elections

New this year, the Nebraska Rural Health conference features a forum as an opportunity for candidates for Governor, U.S. Senate and the First and Third congressional districts to address the participants of the Nebraska Rural Health Conference. The goal of this forum is to give candidates an opportunity to address current issues related to rural health care and to communicate their vision for improving access to quality health care in rural Nebraska. The forum is moderated by John Roberts, Executive Director, Nebraska Rural Health Association, Lincoln, NE.

Additional vital topics offered at the 2006 Rural Health Conference include:

- **Transforming Nebraska Behavioral Health**
- **Critical Access Hospitals: How the Balanced Scorecard is Improving Performance**
- **Health Information Exchange: The Panhandle Planning and Implementation**
- **Medicaid Reform: A Time for Action**
- **Nebraska Registry Partnership: Improving Chronic Disease Management**
- **Saving Lives Through Recruitment and Retention**
- **What We Know and How We Are Transforming Dying in Nebraska**
- **Pandemic: Managing Disaster Preparedness**

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RH Conference *cont'd from p. 2*

- **Early Childhood Mental Health**
- **Medicare Part D and Medicaid: Effecting Rural Pharmacies**

The Nebraska Rural Health Association (NeRHA) is a nonprofit membership organization whose primary mission is to work for the improvement and preservation of rural health in Nebraska. The Association is committed to providing leadership on rural health issues through advocacy, communication and education and to address rural health concerns and develop and promote effective solutions at the local, state and national levels. For more information on NeRHA, contact John Roberts, executive director at (402)421-2356.

As an important component to rural health education and networking, each year, the Nebraska Rural Health conference brings health care practitioners together to learn of advances in health programs that will benefit rural areas of the state. Last year, more than 200 participants attended this conference from primary care and long-term care facilities, clinics, hospitals, governmental, national, and regional agencies, and community-based organizations. Please join us.

Registration, exhibitor, and sponsorship forms are available at www.nebraskaruralhealth.org.

For more information on the conference, please contact Cindy Evert Christ, conference planner, at nerhaconf@alltel.net or 402-470-2569.

For hotel reservations, contact the Kearney Holiday Inn and Convention Center, 110 Second Avenue (Near I-80), Kearney, NE 68848-1925, Ph. 308-237-5971 or 800-248-4460 (NE Only). Please mention that you are with the Nebraska Rural Health Association Conference.

Other Hotels Nearby:

- Wingate Inn, 108 3rd Avenue (directly behind the Holiday Inn) 800-228-1000
- Days Inn, 619 Second Avenue, 800-329-7466, www.daysinn.com
- Ramada Inn, 301 Second Avenue, 800-228-3344, www.kearneyramada.com

Registration Form

Early Registration Deadline: August 14, 2006 *(everyone must register individually)*

Name: _____

Organization: _____

Address/City/State/Zip:_____

Phone:_____ E-Mail:_____

	Through Aug. 14	After Aug. 14
TWO-DAY MEMBERSHIP (September 7-8)		
❑NeRHA Member	$115.00	$130.00
❑Non-NeRHA Member*	$145.00	$160.00
❑Full-Time Student (Students: add $10 if attending banquet)	$25.00	$25.00
❑NeRHA Member	$100.00	$115.00
❑Non-NeRHA Member*	$110.00	$140.00
❑Full-Time Student (Students: add $10 if attending banquet)	$20.00	$25.00

BANQUET:

❑I **have not** registered for the full conference, but **will** be attending the Awards Bankquet on Thursday evening. $20

❑**I have** registered for the conference, but I **will NOT** be attending the Awards Banquet on Thursday Evening. $0

	Through Aug. 14	After Aug. 14
Single Day -- **THURSDAY ONLY**		
❑NeRHA Member	$115.00	$130.00
❑Non-NeRHA Member*	$145.00	$160.00
❑Full-Time Student (Students: **add $10** if attending banquet)	$25.00	$25.00
Single Day -- **FRIDAY ONLY**		
❑NeRHA Member	$75.00	$90.00
❑Non-NeRHA Member*	$100.00	$120.00
❑Full-Time Student (Students: **add $10** if attending banquet)	$20.00	$25.00

TOTAL ENCLOSED: $_____

Make check payable to NeRHA Conference. NeRHA's Federal I.D. is 47-0766519. Sorry, we cannot process credit cards or IBTs.

*Non-NeRHA member will automatically become an Individual Nebraska Rural Health Association member for the remainder of 2006 by registering for this conference.

Send completed form and payment to: Nebraska Rural Health Association CONFERENCE OFFICE, 2301 NW 50th Street, Lincoln, NE 68524; Or Fax to 402-470-2197

Dental Day *cont'd from p. 1*

camera in the patient's mouth linked through the telehealth network lets the faculty member in Lincoln see what the dentist at chair-side is seeing.

If, for example, a lesion is detected in a patient's mouth and the dentist on site desires a consultation, an intra-oral camera linked by the telehealth network allows consultation with a pathologist or periodontist at the Dental College. It may avoid an 8-hour trip each way between the Panhandle and the Dental College.

Dr. Salama says that over the past couple of years, the quality of telehealth has improved greatly. As an example, he pointed to the steady advancements in resolution of intra-oral cameras.

Although telehealth consults are infrequently needed during Dental Day, their availability is valued, according to Dr. Brown. It may be a condition that dentists don't necessarily deal with on a regular basis.

A contingent of about 75 people at the Dental College in Lincoln pack up and head out to the Panhandle for Dental Day, according to Dr. Brown. Among them this year were 24 dental hygiene students, 26 dental students in the junior class and three out of the just-graduated senior class, plus Dental College faculty and IT (information technology) staff and IT equipment. Dental students work on the children under the supervision of volunteering dentists at various sites in the Panhandle.

Thanks to widespread coordination and cooperation among a cadre of dentists, health officials, organizations, and individuals, this year's Dental Day provided free dental care to children at 11 sites in seven Panhandle cities, according to Kim Engel, Panhandle Public Health District Director at Hemingford. Those sites were in Alliance, Gordon, Gering, Chadron, Crawford, Rushville, and Sidney. The estimated value of that free care: $100,000.

That's many more locations than in past Dental Days. Lack of transportation is a "huge barrier" for many families of under-served kids, Engel said. Spreading out to more communities makes the free care more accessible, she said. For the first Dental Day in the Panhandle, parents brought children to a central location, from which they were sent for dental hygiene work and screening, and then to the dentist. Some families, after waiting all day, gave up and went home without care.

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Sponsors and Participants In 2006 Panhandle Dental Day

Many organizations, institutions, companies, and individuals made Dental Day 2006 a reality, including these:

UNMC College of Dentistry; Nebraska Health and Human Services System, Office of Rural Health; Box Butte General Hospital; Gordon Memorial Hospital; Chadron Community Hospital, Sidney Memorial Hospital, Ameritas Insurance Co.; The Sowers Club; Nebraska Dental Hygienists Association; Nebraska Dental Association; Patterson Dental Supply, Inc.; Hu-Friedy; Sullivan-Schein Dental Supply; Proctor & Gamble; the dental offices of Drs. Neal, Kroft, and Printz of Sidney, Drs. Taylor, Maxwell, and Giles of Alliance; Drs. Kaus and Owens of Chadron; Dr. Moody of Crawford; Dr. Snyder of Rushville; Dr. Ferguson of Gordon; Dr. Lambert of Gering; dental hygienists, nurses, and concerned individuals from across the Panhandle; Panhandle Community Services Health Center; Western Community Health Resources; local county prevention teams; Heartland Coach Company; Timberline Autoplex; Pepsi Distributing Company; and the Panhandle Public Health District.

Citizens Health Care Working Group

As part of the Medicare Prescription Drug, Improvement, and Modernization Act Of 2003, the U.S. Congress created the Citizens' Health Care Working Group.

The Citizens' Health Care Working Group has developed Interim Recommendations based on input received from participants in community meetings, respondents to our Web polls, citizens who wrote in to tell us their views, and presenters at public hearings. These recommendations outline a vision and a plan for achieving broad-based change in health care in America.

Interim Recommendations

June 1, 2006

Recommendation 1:
It should be public policy that all Americans have affordable health care

Recommendation 2:
Define a "core" benefit package for all Americans

Recommendation 3:
Guarantee financial protection against very high health care costs

Recommendation 4:
Support integrated community health networks

Recommendation 5:
Promote efforts to improve quality of care and efficiency

Recommendation 6:
Fundamentally restructure the way that palliative care, hospice care and other end-of-life services are financed and provided, so that people living with advanced incurable conditions have increased access to these services in the environment they choose

For more information, visit http://www.citizenshealthcare.gov/recommendations/recsover.php □

Nebraska Rural Health Association awards nomination

Each year, the Nebraska Rural Health Association honors people who have contributed to rural healthcare through leadership at its annual conference. These awards recognize individuals and organizations who take on leadership roles in healthcare and their communities. Each year, the Nebraska Rural Health Association solicits nominations for four awards and your input is very valuable to us.

The **Integrated Rural Healthcare Award** is open to any ***provider*** giving primary care, mental health, and substance abuse collaborative care in rural areas of our state (outside of Douglas, Lancaster and Sarpy counties). The distinction of this award is the collaborative model, the methodology, the types of providers, the issues they are having problems with and the successes they have seen. The provider can be an ***individual, a team, a system or partnership.*** Integration can be with two or all three of the components (primary care, mental health, and substance abuse.) Nominations are accepted from patients, fellow providers, or employees of the provider.

The **Outstanding Rural Health Practitioner Award** recognizes an individual that is a ***direct service provider*** who provides direct patient care such as physicians, nurses, physician assistants, nurse practitioners and others. This individual must exhibit outstanding leadership in bringing and/or improving health services in rural Nebraska. Factors taken into consideration include providing outstanding care; collaboration and multi-disciplinary teamwork; involvement in the community; involvement in education; and lasting contribution to the rural health care system.

The **Rural Health Achievement Excellence Award** recognizes an ***individual in the health care industry*** for leadership and noteworthy initiative in promoting the development of community oriented rural health care delivery. Factors for selection should include: distinctive efforts to promote and/or improve rural healthcare and provide lasting contributions to health care. This award recognizes noteworthy initiatives in the development of community-oriented rural healthcare delivery.

The **Rural Health Distinctive Consumer Advocate Award:** It is important to recognize that rural health care delivery systems will survive only with the involvement of rural consumers. This award honors ***an individual consumer, who is <u>not</u> an employee*** in the health care or health insurance industry, for active participation within his or her community and/or region regarding rural health service delivery issues. For example, the award winner may have testified to the state or national legislature on rural consumers' health care needs or made lasting contributions to rural health care in their community, region, or state. The nominee should be current on rural consumer health care issues and must have shown leadership in community and education regarding health care changes, needs, or improvements.

Awards will be presented at the annual Nebraska Rural Health Conference in September. □

2006 Nebraska Rural Health Awards Nomination Form

Please select the award for which you are nominating an individual or team.

____ Integrated Rural Healthcare Award
____ Outstanding Rural Health Practitioner Award
____ Rural Health Achievement Excellence Award
____ Rural Health Distinctive Consumer Advocate Award

Nominee Name: _____

Address/City/State/Zip: _____

Phone (Office): _____ (Home): _____

Nominee's Organization: _____

Areas (Towns, counties) affected by Nominee's Work: _____

Please attach a description of the nominee's contribution to rural health care, accomplishments and the significance of this person's work. A biographical sketch should be attached. You may also attach news articles and other documentation to support this nomination.

Name of Person/Organization Submitting Nomination: _____

Address/City/Zip: _____

Email Address: _____ Phone: _____

Nominations must be postmarked by: August 1, 2006. *Late nominations will not be considered for awards.*

Mail completed applications to: Nebraska Rural Health Association, 2301 NW 50th Street, Lincoln, NE 68524

Or **Fax** to: 402-470-2197

2006 Annual Nebraska Rural Health Conference Schedule
The Transformation in Rural Healthcare

THURSDAY, SEPTEMBER 7, 2006

8:00 a.m. INTRODUCTIONS
Julie Smith, 2005-2006 President, Nebraska Rural Health Association; Lt. Governor Rick Sheehy

8:15 a.m. GENERAL SESSION
Transforming Rural Health Care: The Basic Ingredients
Mary Wakefield, Health & Director, Center for Rural Health, University of North Dakota, Grand Forks, ND

10:15 a.m.GENERAL SESSION
Health Information Technology: The Future Is Here
Jon White, MD, Health IT Portfolio Manager, Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services

11:30 a.m. LUNCH - Exhibit Area

12:30 p.m. CONCURRENT SESSIONS
1. **Transforming Nebraska Behavioral Health: Where We Have Been, Where We Are, And Where We Are Going.**
   Blaine Shaffer, Chief Clinical OfficerDivision of Behavioral Health Services, Nebraska Health and Human Services System, Lincoln, NE
2. **Critical Access Hospitals: How the Balanced Scorecard is Improving Performance**
   Roger Reamer, CEO, Memorial Health Care Systems, Seward, NE; Linda Shoemaker, VP Patient Care Services, Memorial Health Center, Sidney, NE; William Welch, CHE, CEO, Jefferson Community Health Center, Fairbury, NE
3. **Health Information Exchange: The Panhandle Planning and Implementation**
   Joan Frances, Executive Director, Rural Nebraska Healthcare Network, Kimball, NE; Nancy Shank, Associate Director, University of Nebraska Public Policy Center, Lincoln, NE; Kim Woods, Manager, Western Nebraska Health Information Exchange, Kimball, NE

1:30 p.m.CONCURRENT SESSIONS
1. **Rural Frontier EMS: New Agenda For The Future**
   Gary Wingrove, Manager, Mayo Clinic's Gold Cross Ambulance Service, Buffalo, MN
2. **Medicaid Reform: A Time for Action**
   Dick Nelson, Director, Nebraska Department of Health and Human Services Finance and Support
3. **Nebraska Registry Partnership: Improving Chronic Disease Management – One Clinic at a Time**
   Julie Smith, RN, BSN, MHA, QI Manager, CIMRO of Nebraska, Lincoln, NE

3:00 p.m. GENERAL SESSION
Saving Lives Through Recruitment and Retention
Lee Elliot, Vice President, Saint Francis Medical Center, Grand Island, NE

4:20 p.m. 20-MINUTE SESSIONS
1. **What We Know and How We Are Transforming Dying in Nebraska**
   Jonathan Krutz, MBA, Executive Director, Nebraska Hospice and Palliative Care Partnership
2. **Pandemic: Managing Disaster Preparedness**
   Dr. Joann Schaefer, Chief Medical Officer, Nebraska Health and Human Services System

6:00 p.m. CELEBRATION BANQUET
Everyone is welcome to attend this banquet.

6:30 p.m. CELEBRATING RURAL EXCELLENCE AWARDS

7:30 p.m. ADJOURNED

FRIDAY, SEPTEMBER 8, 2006

7:30 a.m. BREAKFAST ROUND TABLE DISCUSSIONS
1. **Early Childhood Mental Health**
   Tanya Rasher-Miller, LMHP, Project Director, Central Nebraska Early Childhood Mental Health, Grand Island, NE
2. **Medicare Part D and Medicaid: Effecting Rural Pharmacies**
   Joni Cover, Executive Vice President, Nebraska Pharmacists Association, Lincoln, NE
3. **Your Association on the Move – the Future of NeRHA**
   John Roberts, Executive Director, Nebraska Rural Health Association, Lincoln, NE

8:30 a.m. GENERAL SESSION
Federal Rural Health Policy: A View from the Hill
Alan Morgan, Executive Director, National Rural Health Association, Alexandria, VA

9:30 a.m. GENERAL SESSION
Rural Health Policy and the 2006 Nebraska Elections
Moderator – John Roberts, Executive Director, Nebraska Rural Health Association, Lincoln, NE

10:45 a.m. GENERAL SESSION
Transforming Rural Healthcare
Keith Mueller, Ph.D., Professor, University of Nebraska Medical Center

11:45 a.m. NeRHA ANNUAL MEETING
Everyone is welcome to attend

12:30 a.m. ADJOURNED

An assessment of acute stroke treatment in Nebraska hospitals

By Katherine Jones, PhD, PT; Michelle Mason, MA; Michael Shambaugh-Miller, PhD; Liyan Xu, MS; Catherine Leo, BA; and John Brockman

Stroke is the third leading cause of death in Nebraska. Each year, about 1,100 Nebraskans die due to stroke. Between 35 and 50 percent of stroke survivors are permanently disabled or require institutional care, and 37,000 Nebraskans are currently living with a stroke-related disability. The cost associated with stroke in the United States is almost $58 billion per year.

Tissue-type plasminogen activator (tPA) is the one FDA-approved drug that has proven to significantly decrease stroke-related disability. This drug dissolves the blood clot that causes an ischemic stroke before the clot permanently damages the brain. The Nebraska Health and Human Services System contracted with the University of Nebraska Medical Center to assess the readiness of Nebraska hospitals to treat acute stroke, including the use of tPA.

To safely and effectively administer tPA, hospitals must be able to rapidly confirm the diagnosis of ischemic stroke by computerized tomographic (CT) scan, follow strict procedures to determine whether a patient is an appropriate candidate for tPA, and ensure that the drug is administered within three hours of the onset of symptoms. Rural residents may have limited access to this therapy due to distance and limited resources within small rural hospitals.

Study Design

A survey was mailed in December 2005 to the 83 acute care hospitals in Nebraska. The survey was designed to determine the extent to which each hospital had the equipment, procedures, and personnel necessary to treat ischemic stroke.

Of the 83 hospitals surveyed, 60 were critical access hospitals (CAHs) with 25 or fewer beds, seven were small hospitals with 26 to 49 beds, and 16 were larger hospitals with 94 or more beds. Five of the small hospitals have since converted to CAH status. We received completed surveys from 81 (98 percent) of the 83 hospitals; two did not respond to the survey.

Survey Results

Of the 81 responding hospitals, 17 (21 percent) were ready to treat stroke; they could complete a CT scan within 25 minutes, read the results of the scan within 20 minutes, had written procedures for administration of tPA, and could obtain neurosurgical services for patients in-house or by transfer within two hours. Forty-four hospitals (54 percent) were near-ready to treat acute stroke. They had a CT scan available 24 hours a day but lacked at least one of the four additional criteria for readiness. Specifically, of the 44 near-ready hospitals:

- 17 were not able to complete a CT scan within 25 minutes.
- 36 were not able to read the results of the CT scan within 20 minutes.
- 20 did not have a written protocol to administer tPA.
- 4 could not obtain neurosurgical services within two hours.

Twenty hospitals (25 percent) were not-ready. They could not complete a CT scan 24 hours a day.

Hospital size was associated with being ready to treat acute stroke. Only CAHs were categorized as not-ready.

Of the 16 large hospitals,

- 8 were categorized as ready.
- 8 were categorized as near-ready.

Of the 7 small hospitals,

- 1 was categorized as ready.
- 6 were categorized as near-ready.

Of the 58 responding CAHs,

- 8 were categorized as ready.
- 30 were categorized as near-ready.
- 20 were categorized as not-ready.

Barriers to Treating Acute Stroke

Hospitals identified specific barriers that physicians face when determining whether a patient is appropriate for treatment with tPA. These barriers include:

- lack of diagnostic support from a board-certified neurologist (48 percent).
- apprehension about adverse outcomes (47 percent).
- apprehension about litigation (35 percent).
- absence of written protocols for thrombolytic therapy (33 percent).
- inability to complete a CT scan in a timely manner (20 percent).
- lack of radiology support (14 percent).
- lack of laboratory support services (14 percent).

A director of nursing from a CAH commented that "One big barrier is that not all the neurologists in our area agree that small hospitals should be giving tPA, and this worries our physicians ... if we decide to [give tPA] and there is a negative outcome."

The public's lack of knowledge about stroke is also a barrier to treatment. Nearly 91 percent of hospitals agreed that public education about stroke risk factors, warning signs, and activation of emergency medical services (EMS) should be improved. Coordination between hospitals and EMS is also important; 86 percent of hospitals agreed that acute hospitals and EMS providers should develop a coordinated system to ensure that acute stroke patients within a specific

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Patient Records *cont'd from p. 1*

Some of the funding from the grant was used to hire Scientific Technologies to develop recommendations for a patient record-sharing system and a determination of the cost to participants in the system.

Recommendations regarding computer hardware and software are pending. Once that information is available, parties to the southeastern Nebraska consortium will know their costs of participating in the system, Baker said. Funding under the AHRQ grant will end in September, and a RHIO (Regional Health Information Organization) will be formed to continue development and implementation of the patient record-sharing system, she said. The RHIO, the governing body overseeing the patient information-sharing system, will have responsibilities such as the following:

- Developing contractual relationships among healthcare providers for secure, confidential patient record-sharing.
- Developing the structure of the record-sharing system (electronic equipment and software).
- Developing an educational plan for users of the system.
- Developing a funding mechanism for on-going operation of the record-sharing system.

Baker said goals for the system remain what they have been since the beginning more than a year ago. They are:

- Improving patient safety and quality of care.
- Simplifying use of multiple behavioral health services for the consumer.
- Improving standardization of information for behavioral health planning.
- Documenting behavioral health service delivery of care.
- Interfacing hospitals, public health departments, and other primary healthcare professionals with other community service-specific systems to create a more integrated system database.

A critical part of developing a record-sharing system lies in formatting records so that participating healthcare providers can import the records into each other's systems without running into compatibility problems.

The formatting must take into account other electronic patient record-sharing systems being developed elsewhere in the state and national, Baker said. For example, the record-formatting effort in southeastern Nebraska is maintaining lines of communication with a Nebraska Panhandle project that includes development of a patient record-sharing system there, Baker said.

At the same time, the southeastern Nebraska system is being created with the idea that it will eventually tie in with a nationally standardized record-sharing system called ONCHIT (Office of the National Coordinator for Health Information Technology). "We don't want to get too far ahead of it," Baker said.

Created by administrative order from the White House, ONCHIT is encouraging development of various pieces of a universal, interoperable, digital health record system throughout the country, said Dennis Berens, director of the Nebraska Office of Rural Health. Such a system would ultimately link together all the healthcare pieces, he said. Primary and behavioral healthcare providers, pharmacists, dentists, long-term care, and others would make up this system, which will, essentially, provide a "digital everything," Berens said.

Shared electronic health record systems like the one being developed in southeast Nebraska require attention to standardization if those records are ultimately to be made interoperable among healthcare providers nationwide as envisioned.

Berens said broad interconnectedness among healthcare providers nationally is vital to helping provide quality care, and contain ever-rising healthcare costs. Further, such a system will be important to better understanding how to address population-based public health issues, and chronic care issues such as diabetes and heart disease.

Behind the southeast Nebraska program is a consortium comprised of Heartland Health Alliance (a 38-hospital organization), BryanLGH Medical Center in Lincoln, Mental Health Region V, Blue Valley Mental Health Center, Community Mental Health Center of Lincoln/Lancaster County, and Health Partners Initiative (a non-profit consortium of healthcare providers and businesses in the Lincoln-Lancaster County area). □

Dental Day *cont'd from p. 4*

Now, Engel explained, children are prescreened with appointments made in advance of Dental Day. Their families are contacted a day ahead to remind them of their appointments on Dental Day.

Responsible for coordinating the event in the Panhandle, Engel communicated with local dental offices, hospitals, and the dental college. To identify under-served kids for care during Dental Day, she worked with community resources, such as school nurses, Western Community Health Resources, Panhandle Community Health Services Center, Twenty-first Century After School Program, and Box Butte Family Focus.

Screenings and X-rays at the volunteering Panhandle dental offices began in April, in preparation for the children's appointments and treatments on Dental Day, Friday June 2, and into Saturday, June 3. For some children who had especially extensive dental care needs, split appointments on Dental Day were arranged, and in several cases, provisions were made for care under general anesthesia at Box Butte General Hospital in Alliance.

"Those local dentists have made a tremendous effort by pre-screening the kids and offering their offices," Engel said. "Without them, none of this would be possible. Our hats go off to these local dentists and local recruiters (who identify under-served children for dental care).

"One spinoff from this, for western Nebraska, is an opportunity to have a whole class of dental professionals come and see our area and meet the professionals who are here." That may encourage those dental students, when they go into practice, to establish their practice in this part of the state, she added.

Engel said the IT people at the Dental College in Lincoln and at the remote sites in the Panhandle do an excellent job of making telehealth technology available for Dental Day. But, the value of telehealth goes well beyond consults on that day, she added. Telehealth interactive video conferencing proved to be a very valuable tool in planning Dental Day. "We use telehealth video conferencing several times a week, not just for Dental Days," Engel said of the Panhandle Public Health District. All hospitals in Panhandle communities have telehealth systems and IT personnel available. "They (hospitals) are very generous in offering their systems (to us)."

Because we are rural, telehealth often makes it possible to save a trip across the state, a major money and time saver. Any trip to Lincoln or Grand Island, at a minimum, costs $1,000, she said.

All but three of the sites at which children were treated during this year's Dental Day had high-speed data lines for telehealth links to the Dental College.

As Dr. Brown noted earlier, consults between dentists on-site and faculty at the college for purposes of diagnoses have been infrequent. One reason is that dentists at the sites are well trained and quite competent, "able to handle about any dental problem that walks in the door," he said. He sees a more likely role for telehealth in dentistry with electronic supervision or monitoring as opposed to in-person supervision. And, like Engel, he sees a growing telehealth role in dentistry in interactive video conferencing for planning and continuing education.

Engel said, "I'm thinking that if dental students can see it (telehealth) in action and realize that's a possibility, it's just one more tool in their toolbox, especially in a rural area."

Dr. Salama at UNMC sees Dental Day, boosted by telehealth capabilities, as a great service to under-served clientele. "I hope this will continue." □

MARK YOUR CALENDARS

Certified Rural Health Clinics Billing/Coding Workshops
September 5-6, 2006
Holiday Inn, Kearney, NE

Annual Nebraska Public Health Association Conference
September 21-22, 2006
I-80 Holiday Inn – Grand Island, NE

Rural Health Advisory Commission Meeting
September 6, 2006; 6:30 p.m.
Holiday Inn, Kearney, NE

Annual Minority Health Conference
October 31 - November 1, 2006
Holiday Inn, Kearney, NE

Annual Nebraska Rural Health Conference
September 7-8, 2006
Holiday Inn, Kearney, NE

Kathleen Duncan, Ph.D., appointed assistant dean, UNMC College of Nursing Lincoln Division

By Vicky Cereno

Kathleen Duncan, Ph.D., associate professor of nursing, UNMC College of Nursing Lincoln Division, recently assumed the role of assistant dean. She succeeds Lani Zimmerman, Ph.D., who has held the position since 1995.

As assistant dean, Dr. Duncan will be responsible for providing leadership in planning, organizing and securing the necessary resources to accomplish the division's goals and objectives.

Dr. Duncan said among her goals is to pull the division's resources together. "Changes will allow us to better meet our needs and facilitate better communication and collaboration," she said. "I want to see us continue to thrive, get more efficient and reduce barriers to make things even better for people."

She has a solid foundation on which to begin. "The division is strong, with excellent faculty, staff and students. There's a growing demand for graduate programs and we have several research grants. Our graduates are in demand. We hear that all the time."

Dr. Duncan's responsibilities also include securing student clinical experiences in Lincoln health care facilities. As in Omaha, Kearney and Scottsbluff, Lincoln nursing students compete for clinical patient experiences supervised by faculty.

There are five schools with nursing programs in Lincoln.

"There's limited clinical availability," Dr. Duncan said. "All the schools sit down and submit requests. The schools work with each other to meet each others' needs."

One of her favorite parts of teaching comes at the end of the semester when students present their semester projects. "I tell people I don't need to be paid during the weeks I see students present projects in their community clinical settings. I'm always amazed at how well they know their data and how they see themselves not just as a nurse, but part of the system."

Virginia Tilden, D.N.Sc., dean of the UNMC College of Nursing, said she is delighted Dr. Duncan accepted the appointment.

"She brings a wealth of experience in nursing education and also a deep knowledge of the Lincoln community. Her background in administration and health systems positions her for great success in this role," Dr. Tilden said.

Dr. Duncan earned her bachelor's degree in nursing in 1973 from Arizona State University College of Nursing in Tempe, her master's degree in nursing in 1983 at UNMC and doctoral degree at the University of Nebraska-Lincoln in 1994.

She became an assistant instructor at the UNMC College of Nursing in 1980 and was promoted to associate professor in 2001.

From 1974 to 1979, Dr. Duncan was a unit manager and charge nurse in a medical-surgical unit in St. Joseph Hospital in Tucson. Prior to that, she worked in a trauma/burn unit in Phoenix.□

Stroke *cont'd from p. 7*

area are transported to the facility best equipped and staffed to treat them.

Finally, geographic isolation is a barrier to treatment. Based upon the number of times each hospital reported having given tPA, we estimated that the rate of treatment of acute stroke with tPA is approximately four to five times greater in eastern urban areas than in remote rural areas of the state.

Need for a Statewide System of Stroke Treatment

The Nebraska Statewide Telehealth Network is an interactive video and data network that integrates hospitals, public health departments, and public health laboratories across the state. The goals of the network are to minimize distance as a barrier to high quality health care; provide education to patients, providers, and the community; and provide a means of communication during emergencies. According to consultant Dave Glover, all of Nebraska's rural hospitals are connected to the network and use it for patient consultations and continuing education. Academic medical centers in Georgia, Texas, and Maryland have successfully completed small pilot projects using telemedicine to connect neurologists with remote hospitals for acute stroke consultation.

Through its telehealth network, Nebraska has the potential to establish a coordinated, statewide system of stroke treatment. To achieve this system and minimize death and disability due to stroke across Nebraska, hospitals, neurologists, radiologists, EMS, and public health officials must collaborate to:

- improve public education regarding stroke as a medical emergency.
- ensure that suspected stroke patients are rapidly evaluated and transported to hospitals that can diagnose and initiate tPA treatment using an onsite CT scanner and timely treatment protocols.
- ensure that diagnostic support is available from neurologists and radiologists for every hospital that treats acute stroke. □

Taxation on loan repayments— another hurdle in recruiting rural family physicians

By Don Frey, M.D., Chairman, Rural Health Advisory Commission

State and local programs that help students repay a portion of their medical school loans are designed to help counteract the increasing burden of student debt. But a loophole in federal law is preventing some students from benefiting fully from the loan repayment programs.

Now, the Rural Health Advisory Commission needs your help in trying to correct this problem, which arises from differences in the provisions of federal and state plans.

The federal program, which offers loan repayments through the National Health Service Corps, (NHSC), requires students to practice in federally designated shortage areas.

When Nebraska established its own loan repayment program in 1994, authorities realized many Nebraska communities in desperate need of physicians would not strictly meet the rigid definition for a federal shortage area. So the state established its own criteria for shortage areas and loan repayment. And the program, a cooperative effort between state and local communities, has worked, attracting many physicians to rural areas.

But there's a catch. The loan repayment money the physician receives from the state-funded program is subject to federal income taxes on the same basis as earned income; consequently, a significant chunk of the money disappears before it can be used to repay the loan. And with rising medical school tuition, a loan repayment sum that is greatly reduced through taxation is often insufficient to attract the graduate to an underserved region.

Recognizing the problem, the U.S. Congress voted to exempt loan repayments through the NHSC from federal taxes and also to exempt certain state programs "eligible for funds under the Public Health Service Act" from taxation.

But, despite its strong track record of success, the Nebraska program does not qualify for tax exemption because it does not meet the specific requirements of the Public Health Service Act. The Nebraska program: (1) does not necessarily place health professionals in federally designated shortage areas; (2) does not insist that the practitioner use a sliding fee scale; and (3) allows part-time practice in shortage areas.

Nebraska is not alone in this unfair situation. The Office of Rural Health found that, of the 13 or more other states with state-funded repayment programs, more than half define their shortage areas differently from federal shortage areas. Four states allow part-time practice.

Although nine of the 13 states report loan repayments to the Internal Revenue Service for tax purpose, two states that clearly do not meet the Public Health Service Act requirement choose not to report this information. Although this would seem to put these states at odds with the law, they continue to stand by their decision not to report loan repayment to the IRS.

Given this confusing scenario, it appears that Nebraska health professional graduates who wish to practice in rural communities are being held to an unfair standard. Recruiting health professionals for rural communities is difficult under the best of conditions, but it is even more difficult when graduates are forced to compete on a playing field that is far from level.

The Rural Health Advisory Commission has sent letters to the members of the Nebraska congressional delegation asking them to investigate the feasibility of changing the federal law to recognize successful state loan repayment programs like Nebraska's. The senators and representatives have said they are willing to take on the problem, but they need more information to make their case. They need to know how the tax liability associated with the loan repayment programs is affecting health care needs in local areas.

This is where you come in.

When you are trying to recruit new health professionals to your community, how does the taxing of loan repayment awards affect your efforts? Have there been circumstances in which a young health professional who chose not to come to your community through a loan repayment program might have been more inclined to join your health care program had his or her loan repayment not been taxed?

If you can demonstrate the impact of taxation on the Nebraska Loan Repayment Program at the community or health professional level, please send a letter describing your experience to: Rural Health Advisory Commission; c/o Nebraska Office of Rural Health; P.O. Box 95007 ; Lincoln, NE 68509-5007.

If you have questions about this issue, or suggestions for the commission, please contact Marlene Janssen at the Nebraska Office of Rural Health at (402) 471-2337. □

ACCESSory Thoughts

Dennis Berens, Director
Nebraska Office of Rural Health

A New Paradigm

A few weeks ago, I finished reading *If Disney Ran Your Hospital* by Fred Lee. This book appears to have been written to move the health care industry to another paradigm, and I encourage all of you, no matter what work you do, to look at this proposed paradigm shift.

I struggled to make sense out of the author's proposal and finally found a perspective that helped me to understand this new model: We are now in the knowledge age, not the industrial age.

The author notes that Disney identifies its competition as anyone its customers compare it to. Wow! What if all health care providers had the same view?

Lee notes that patients judge their experience by the way they are treated as people, not by the way they are treated for their diseases. He shares Press Ganey Associates and Gallup Organization studies that point to these top patient satisfaction drivers: how well staff worked together to care for a patient; response to patient concerns; amount of attention paid to personal/special needs; staff sensitivity. The patients assume that providers will always give them a good outcome.

Lee says, "When hospitals spend most of their efforts in clinical results and process improvement, their data are defined by outcomes and, therefore, can be measured objectively. The patient, however, judges quality by his or her perceptions, something that is subjective and cannot be verified in the same way as outcomes." Later, he says, "The first thing to have clear is that outcomes are delivered by teams, whereas impressions are delivered by individuals."

So how does this relate to the new knowledge age? I believe the evolution that is going on now enables all of us to become more empowered with the new ways of thinking and the information systems that our creative thinkers are designing for us. According to some surveys, the most trusted source of health information is the Web. With information comes knowledge and questions. With telecommunication comes new access possibilities and maybe more care.

In other words, health care seems to be entering the customer age and will now need to compete for that customer in new ways and with different strategies. The customer now has more options to choose from.

This could be just what rural providers have been waiting for. You already have relationships with your customers but often lack the time to do more or to know more. Technology can now help provide more information, make the visit more complete and thorough and enable communications to go to different levels. We can do registries to help our chronic patients. We can set up support groups for our special needs patients. We can receive information from our patients in their homes. And we can work with specialists at the same time that we see a patient.

The issue is not outcomes over perceptions but how to constantly improve our quality of the care we provide, while spending a lot more time making sure that our customers' perceptions of the care we deliver are considered and valued. This is the new "reality of the ideal" that health care providers should be thinking about.

Remember, your customer is always comparing you to someone else. □

ACCESS
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